Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Cetuximab

INITIATION

Prerequisites (tick boxes where appropriate)

❍ Prescribed by, or recommended by a medical oncologist, or in accordance with a protocol or guideline that has been endorsed by the Te Whatu Ora Hospital.

and

❍ Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck

and

❍ Patient is contraindicated to, or is intolerant of, cisplatin

and

❍ Patient has good performance status

and

❍ To be administered in combination with radiation therapy

I confirm that the above details are correct:

Signed: ..... Date: .....